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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>335637 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>09/10/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brooklyn-Queens Nursing Home |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2749 Linden Blvd<br>Brooklyn, NY 11208 |  |

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44843</b></p> <p>Based on record review and interviews conducted during the Recertification survey from 09/03/2024 to 09/10/2024, the facility did not ensure that, to the extent practicable, the resident or resident representative participated in the development, review, and revision of the comprehensive care plan. Specifically, Resident #78 and/or their designated representative were not afforded the opportunity to participate in the initial care plan meeting. This was evident in 1 out of 3 residents reviewed for Care Plan.</p> <p>The findings are:</p> <p>The facility policy titled Care Planning Process with an effective date of 11/12/20 and last revised date 6/24 stated that Resident/family/responsible parties will be invited to the comprehensive care plan meeting by the Social Work department. The policy also stated that every effort will be made to accommodate attendance at these meetings. The policy further stated that an explanation should be documented in the medical record if it was determined that participation of the resident or representative is not practicable for the development of the care plan.</p> <p>Resident #78 had diagnoses which included Major Depressive Disorder, Multidrug Resistant Organism and End Stage Renal Disease.</p> <p>The Admission Minimum Data Set assessment dated [DATE] documented that Resident #78 was cognitively intact and had no behavior issue.</p> <p>Section Q0110 of the Admission Minimum Data Set documented that Resident #78, nor their representative participated in the assessment.</p> <p>On 09/03/2024 at 10:42 AM, Resident #78 was interviewed and stated they were admitted to the facility about three months ago and did not recall being invited to a care plan meeting. Resident #78 also stated they made decision themselves.</p> <p>The Care Plan Meeting report documented the initial care plan meeting was held on 06/27/2024. and did not document that Resident # 78 and/or their representative attended the meeting.</p> <p>There was no documented evidence in the medical record that Resident #78 and/or their representative were invited to or participated in the care plan meeting on 06/27/2024.</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Social Services notes dated 06/27/2024 to 08/28/2024 contained no documented evidence that Resident #78 and/or their representative was invited to a care plan meeting.</p> <p>On 09/06/2024 at 10:52 AM, Licensed Practical Nurse #1 was interviewed and stated Resident #78 was cognitively intact, made decision themselves, and did not refuse care. Licensed Practical Nurse #1 also stated the Social Worker was responsible to invite the resident and/or their representative to the care plan meeting.</p> <p>On 09/06/2024 at 11:46 AM, the Director of Social Services was interviewed and stated they provide social services for Resident #78, and they invited the resident and/or their representative to the care plan meeting about one week ahead of the scheduled care plan meeting. The Director of Social Services also stated the invitation to care plan meeting had to be documented in the medical record as a proof an invitation was done. The Director of Social Services further stated Resident #78 was alert and oriented and made decision themselves. The Director of Social Services reviewed the medical record of Resident # 78 and could not locate or provide any documented evidence that Resident #78 and/or their representative were invited to the initial care plan meeting on 6/27/2024. The Director of Social Services stated it was an oversight that Resident #78 and/or their representative were not invited to care plan meeting.</p> <p>10 NYCRR 415.3(f)(1)(v)</p> |   |  |

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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41709</b></p> <p>Based on record review and interviews conducted during the Recertification survey from 09/03/2024 to 09/10/2024, the facility did not ensure that the Minimum Data Set 3.0 assessments were accurately coded to reflect the residents and/or their representatives' participation in the assessment and goal setting. This was evident for 3 (Resident #18, #7, and #78) out of 31 total sampled residents. Specifically, the Minimum Data Set assessment for Residents #18, #7, and #78 did not accurately code that the residents participated in the assessment.</p> <p>The findings are:</p> <p>The facility policy titled MDS (Minimum Data Set) assessment with an effective date of 11/12/20 and last revised 6/24 documented Social Work was assigned to complete section Q in the Minimum Data Set assessment.</p> <p>1. Resident #18 had diagnoses of Hypertension, Peripheral Vascular Disease, and Chronic Respiratory Failure.</p> <p>During an interview on 09/10/24 at 09:56 AM, Resident #18 stated they always take part in the Care Plan meeting and talks with the team about their plan of care.</p> <p>The Quarterly Minimum Data Set 3.0 assessment dated [DATE] documented Resident #18 was cognitively intact, had no behavior problems, and no rejection of care. Section Q 0110, Participation in Assessment and Goal Setting, in the assessment documented none of the above and did not reflect that Resident #18 had participated in the assessment.</p> <p>44843</p> <p>2. Resident #7 had diagnoses which included Congestive Heart Failure, Major Depressive Disorder, and Unspecified Pain.</p> <p>On 09/10/2024 at 09:31 AM, Resident #7 was interviewed and stated the staff from different disciplines met with them for assessment about every 3 months.</p> <p>The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #7 was cognitively intact and did not reject care. Section Q 0110, Participation in Assessment and Goal Setting, in the assessment documented none of the above and did not reflect that Resident #7 had participated in the assessment.</p> <p>3. Resident #78 had diagnoses which included Major Depressive Disorder, Multidrug Resistant Organism and End Stage Renal Disease.</p> <p>On 09/10/24 at 09:46 AM, Resident #78 was interviewed and stated the interdisciplinary team members visited them at the beginning of admission and again last week for assessment.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>The Admission Minimum Data Set assessment dated [DATE] documented Resident #78 was cognitively intact and did not reject care. Section Q 0110, Participation in Assessment and Goal Setting, in the assessment documented none of the above and did not reflect that Resident #78 had participated in the assessment.</p> <p>On 09/09/2024 at 03:08 PM, the Minimum Data Set Coordinator was interviewed and stated they interviewed the residents and/or representatives for the Minimum Data Set assessment. The Minimum Data Set Coordinator also stated that the Social Service department was responsible to answer the question Q0110, Participation in Assessment and Goal Setting, in section Q of the assessment. The Minimum Data Set Coordinator stated they were not responsible for the accuracy of the Minimum Data Set assessment but to make sure the Minimum Data Set assessments were completed and submitted in a timely manner.</p> <p>On 09/09/2024 at 03:23 PM, the Director of Social Services was interviewed and stated their department answered the question Q 0110 - Participation in Assessment and Goal Setting in the Minimum Data Set assessment. The Director of Social Services also stated the interdisciplinary team did involve the residents and/or their representatives for the Minimum Data Set assessment. The Director of Social Services further stated that it was the Assistant Director of Social Services' responsibility to answer question Q 0110. The Director of Social Services stated the Assistant Director of Social Services left the facility several weeks ago. The Director of Social Services further stated it was an error to code that residents and/or their representatives had not participated in the assessments. The Director of Social Services also stated that they provided training to the Assistant Director of Social Services and reviewed the completed assessments for accuracy of the Social Services section after the training, then discontinued doing so when there were no concerns with the way the assessments were completed.</p> <p>On 09/10/2024 at 10:01 AM, the Administrator was interviewed and stated the interdisciplinary team had the residents and/or their representatives participate in the Minimum Data Set assessment. The Administrator also stated they were not aware it was coded to reflect that the residents and/or their representatives did not participate in the assessments. The Administrator further stated it may be misunderstanding of the question that the staff answered question Q 0110 incorrectly.</p> <p>10 NYCRR 415.11(b)</p> |   |  |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41709</p> <p>Based on observations, record review and staff interviews conducted during the Recertification survey and Complaint survey (NY00348151) from 09/03/2024 to 09/10/2024, the facility did not ensure that residents comprehensive care plans were reviewed and revised to reflect the resident's status. This was evident for 1 (Resident #91) of 2 residents reviewed for Activities of Daily Living, 1 (Resident #105) of 6 residents reviewed for Abuse and 1 (Resident #7) of 5 residents reviewed for Unnecessary Medication out of 31 sampled residents. Specifically, 1). Resident #91's comprehensive care plan was not reviewed and revised to reflect their preference for wearing hospital-style gowns, and refusal to have their hair care needs addressed, 2). Resident #105's comprehensive care plan related to Victimization was not reviewed and revised after the Minimum Data Set Assessment was completed, and 3). Resident #7's comprehensive care plans related to Pain and Anticoagulant use were not reviewed or revised after the Minimum Data Set Assessment was completed.</p> <p>The finding is:</p> <p>The facility policy titled Care Planning Process last revised 6/24 documented comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team. The policy further documented care plans must be reviewed and modify as needed by appropriate disciplines prior to scheduled care plan meeting. Each comprehensive care plan problems, goals and interventions should be reviewed for appropriateness to the resident's condition. Each care plan should have a review note completed prior to/during the comprehensive care plan meeting evaluating effectiveness.</p> <p>1. Resident # 91 had diagnoses which includes Depression, Paranoid Schizophrenia, and Insomnia.</p> <p>The Quarterly Minimum Data Set, dated dated [DATE] documented that Resident #91 had severely impaired cognition and required supervision to set up assistance for shower and bath and was independent with personal hygiene. The Quarterly Minimum Data set further documented Resident #91 had physical behavioral symptoms directed toward others, other behavioral symptoms not directed toward others such as pacing, and there was no rejection of care.</p> <p>On 09/03/24 at 12:40 PM, Resident #91 was observed eating lunch in the unit dining area wearing hospital-type gown. Resident #91's hair appeared long on the sides and there was a large, matted clump of hair at the back of Resident #91's head.</p> <p>On 09/04/24 at 09:40 AM, Resident #91 was observed walking in the hallway and entered dining area wearing a hospital-type gown. Hair to the back of Resident #91's head was observed to be in a matted clump.</p> <p>On 09/05/24 at 09:05 AM, and on 09/05/24 at 11:29 AM, Resident #91 was observed walking from the dining area to their room in a hospital-type gown with hair that remained matted to the back of resident's head in long clump. Resident #91 did not answer when greeted.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>On 09/09/24 at 09:03 AM, on 09/09/24 at 11:51 AM, and on 09/10/24 at 08:51 AM, Resident #91 was observed walking on unit from dining area to room in a hospital-type gown. Resident #91 continued to have a clump of matted hair to the back of the head.</p> <p>The Comprehensive Care Plan titled Functional Status: Self Care effective 1/17/2024 and last updated documented 7/24/2024 documented Resident #91 required supervision/touching assistance for shower/bathe self and was independent for Personal Hygiene. Interventions included encourage resident to perform self-care as independently as possible, observe for safety, review progress or lack of progress toward discharge goals and update as needed, and continue annual and quarterly assessments to monitor status.</p> <p>The Comprehensive Care Plan titled Behavioral Symptoms Etiology: Resident exhibits behavior problems as evidenced by refusing medications, psychiatric diagnosis of Paranoid Schizophrenia dated effective 4/3/2024 with last evaluation note dated 7/17/2024. Interventions included monitor behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, and situations, document behavior and potential causes, re-enforce/praise positive behavior and progress, explain to resident the risk of non-adherence and risk of negative outcomes/impact, and refer to physician/psychiatrist as needed.</p> <p>The Certified Nursing Assistant Accountability Record dated January 2024 through September 2024 documented resident received showers and contained no documented evidence that Resident #91 refused care or refused to clean their hair. There was no documentation of Resident #91's preferences for care on the Certified Nursing Assistant Accountability record.</p> <p>The Comprehensive Care Plan meeting dated 10/26/2023, 1/30/2024, 5/2/2024 and 8/1/2024 documented Resident #91 was receiving showers, but there was no documented evidence that Resident #91 Activities of Daily Living, specifically hair grooming and preference for gowns was addressed with Resident #91 and/or representative.</p> <p>The Nursing progress note dated 07/16/2024 at 10:34 AM, documented behavior Note: Even with much encouragement resident refuses to let hair get washed and to put on clothing- prefers to wear the gown.</p> <p>There was no documented evidence that Resident #91's care plan was reviewed or revised to include their preference for hospital-style gowns, or to include interventions and or a plan to address Resident #91's matted and unkempt hair.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During an interview on 09/06/24 at 10:28 AM, Certified Nursing Assistant #8 stated that they were assigned to care for Resident #91 last month and the only thing Resident #91 allowed Certified Nursing Assistant #8 do for them is provide them with two hospital-style gowns, make their bed, and give them their breakfast and lunch trays. Certified Nursing Assistant #8 also stated that Resident #91 handled all other care by themselves and refused to dress in anything other than hospital-style gowns. Certified Nursing Assistant #8 further stated that Resident #91 would only shower when they wanted to shower, despite having designated days to shower on Mondays and Thursdays and they always refused to have their hair washed or cut. Certified Nursing Assistant #8 stated that Resident #91 needed a lot of encouragement to go into the shower, and during shower time the Certified Nursing Assistant stays with Resident #91 but cannot touch their hair. Certified Nursing Assistant #8 stated they were aware of Resident #91's hair needs care, and they did not document that Resident #91 refused to clean their hair because there was no place to document this. Certified Nursing Assistant #8 stated they verbally inform the nurse on the unit that Resident #91 is refusing to wash their hair.</p> <p>During an interview on 09/06/24 at 02:06 PM, Licensed Practical Nurse #2 stated they are aware that Resident #91's hair is matted and cannot be combed out, and they have personally offered Resident #91 a haircut on multiple occasions, but Resident #91 refused. Licensed Practical Nurse #2 also stated that Resident #91 does not like to be touched and walks around in a hospital-style gown all day. Licensed Practical Nurse #2 further stated that Resident #91 is independent with Activities of Daily Living, is compliant with all medications, very engaging, low speech, has no combative behaviors at present. Licensed Practical Nurse #2 stated that they reported the noncompliance with hair care and matted hair to the supervisor and Social Worker, but nothing was done. Licensed Practical Nurse #2 also stated they do not participate in the care planning meetings and did not document the multiple times they offered Resident #91 a haircut.</p> <p>During an interview on 09/06/24 at 02:50 PM, Registered Nurse Supervisor #2 stated that Resident #91 walks up and down in the hallway in a hospital-style gown. Registered Nurse Supervisor #2 also stated that Resident #91 was admitted with matted hair and Resident #91 was encouraged to clean hair during an interdisciplinary team meeting, but they could not recall when this was. Registered Nurse Supervisor #2 further stated that they have approached Resident #91 on several occasions to offer a shower which Resident #91 accepted, but Resident #91 refuses to allow anyone to touch their hair. Registered Nurse Supervisor #2 stated if anyone attempts to touch their hair, Resident #91 turns red, folds arms, and says no, no and walks up and down the hallway. Registered Nurse Supervisor #2 also stated they did not document any of the meetings with Resident #91 or the plan for Resident #91, but there was a note in July 2024 stating that Resident #91 refused to have hair washed, and their preference was to wear hospital-style gowns on the unit. Registered Nurse Supervisor #2 stated they are not responsible for care plans and did not initiate or update the care plan for resident preference of gowns and refusing to wash hair as there was someone specifically assigned to do the care plans, but they are not sure what happened to that.</p> <p>During an interview 09/10/24 at 01:38 PM, the Director of Nursing stated were just told that the Resident #91 had matted hair, was resistive to care, refused activity of daily living care. The Director of Nursing also stated Registered Nurse Supervisors are responsible for creating and revising all care plans and they would instruct them to ensure that the appropriate care plans are in place for Resident #91.</p> <p>44843</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>2. Resident #105 (NY00348151) was admitted to the facility with diagnoses which included Vascular Dementia, Cerebral Atherosclerosis, and Cerebral Infarction.</p> <p>The Admission Minimum Data Set 3.0 assessment dated [DATE] documented Resident #105 was had severely impaired cognition and no physical/verbal behavioral symptoms directed toward others.</p> <p>The Nursing note dated 7/12/2024 documented Resident #105 was observed with discoloration on the left upper arm area which was blueish in color and in the size measured 10cm x 5 cm.</p> <p>The Medical note dated 7/15/2024 documented date of service was on 7/12/2024 to assess Resident #105 for complaint of bruise with mild hematoma over the left arm. The Medical note also documented that Certified Nursing Assistant reported to the nurse that Resident #105 had a bruise over the left arm. The Medical Note further documented that Resident #105 was not able to give a proper history due to poor cognitive function. The Medical note documented that the Certified Nursing Assistant and nurses did not see Resident #105 falling from their bed or was there any history of accidents happening while Resident #105 was in their room.</p> <p>The Accident /Incident Occurrence Report/Investigation form documented the occurrence happened at 12:00 PM on 7/12/2024.</p> <p>The Comprehensive Care Plan related to Victimization created 4/16/2024 documented interventions which included to keep Resident #105 separated from other residents possibly disturbed by the behaviors exhibited whenever possible, provide a safe environment, and provide emotional support/reassurance for Resident #105 to express feelings.</p> <p>There was no documented evidence Resident #105's comprehensive care plan related to Victimization was reviewed and/or revised after Resident #105 was observed with an injury of unknown source or after the Admission Minimum Data Set assessment was completed on 4/23/2024 or the Quarterly Minimum Data Set assessment completed on 7/24/2024.</p> <p>3. Resident #7 had diagnoses of Unspecified Atrial Fibrillation, Unspecified Pain, and Chronic Pain Syndrome.</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #7 was cognitively intact. The Minimum Data Set assessment also documented that Resident #7 received anticoagulant and opioid medication.</p> <p>The Physician's order dated 10/21/2023 renewed on 9/3/2024 documented that Resident #7 was to receive Oxycodone-Acetaminophen 10mg-325mg tablet, 1 tablet by mouth every 6 hours for Pain.</p> <p>The Physician's order dated 11/10/2022 renewed on 9/3/2024 documented that Resident #7 was to receive Eliquis 5 mg tablet, give 1 tablet by mouth every 12 hours for Unspecified Atrial Fibrillation.</p> <p>The Medication Administration Record dated August 2024 documented that Oxycodone-Acetaminophen and Eliquis were administered to Resident #7 every day as ordered.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>The Comprehensive Care Plan with focus on Pain created on 11/10/2022 and last updated 3/29/2024 included interventions of assess for breakthrough pain and need for supplemental doses, assess nature, intensity, location, duration, and frequency of pain, and educate Resident #7 and/or family regarding importance of reporting pain and pain control.</p> <p>The Comprehensive Care Plan with focus on Anticoagulant Use initiated 11/10/2022 and last updated 5/13/2024 documented interventions which included to administer medications as per Medical Doctor orders, avoid bumping and handle resident gently when providing hands on care, and monitor/document/report to Medical Doctor as needed for signs/symptoms of anticoagulant and/or antiplatelet complications.</p> <p>There was no documented evidence that Resident #7's comprehensive care plans related to Pain and Anticoagulant Use were reviewed or revised after the last Minimum Data Set assessment completed on 6/3/2024.</p> <p>On 09/05/2024 at 02:17 PM, Registered Nurse #1 was interviewed and stated they were responsible for reviewing the care plans for residents at least every three months after the Minimum Data Set assessments and as needed. Registered Nurse #1 also stated they were able to check which residents were due for Minimum Data Set assessment in the electronic medical record system and review their care plans accordingly. Registered Nurse #1 further stated they updated or documented to continue the care plan if no change was needed. Registered Nurse #1 stated they updated some care plans for Resident #105 and #7, and it may be an oversight that all care plans were not updated.</p> <p>On 09/09/2024 at 10:17 AM, the Director of Nursing was interviewed and stated the day shift Registered Nurse for the unit was responsible for reviewing and updating the care plans at least every three months after the Minimum Data Set assessment and as needed. The Director of Nursing also stated the Registered Nurse is supposed to document the care plan was reviewed and continue the current care plan if there was no change in the care plan. The Director of Nursing reviewed the medical record and was not able to explain why some care plans were not reviewed or updated in a timely manner for Resident #105 and Resident #7. The Director of Nursing stated the registered nurses were professional and they did not monitor if the Registered Nurse had reviewed and updated the care plans.</p> <p>10 NYCRR 415.11(c)(2)(iii)</p> |   |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>335637  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>09/10/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brooklyn-Queens Nursing Home   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2749 Linden Blvd<br>Brooklyn, NY 11208 |  |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |   |   |  |
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |   |  |
| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42101</p> <p>Based on observations, record review, and interviews conducted during the Recertification Survey from [DATE] to [DATE], the facility did not ensure that food was stored in accordance with professional standards for food service safety. This was evident during the kitchen task and pantry inspections. Specifically, there were multiple expired food items in the kitchen dry storage room, emergency food room, and in the pantry on the 5th floor.</p> <p>The findings are:</p> <p>The facility policy titled Storage Procedure revised ,d+[DATE] documented food shall be received and stored in a manner that complies with current practices for safe food handling. Dry foods that are stored in bins will be removed from original packaging labeled and dated (use by date). Such foods will be rotated using a first in - first out system.</p> <p>An initial tour of the kitchen and emergency food storage area was conducted on [DATE] from 09:16AM-09:53AM with Dietary Aide #2 and Dietitian. In the dry storage room of the kitchen 10 cardboard boxes of 24 count 8 ounces Jevity 1.5 with use by dates of 1 [DATE] and 1 [DATE], and one box containing 33 individual containers of 4-ounce Ready Care Clear Choice Thickened Lemon-Flavored Water with a marked expiration date of 10 [DATE] were observed. In the emergency food storage area Boost Pudding Rich chocolate with expiration date of 30 [DATE], and Two Cal HN containing 23 cartons of 8 ounce with use by date of 1 [DATE] were observed.</p> <p>During a tour of the pantry on the 5th floor on [DATE] at 11:00AM-11:01AM, a box containing 21 cartons of Nepro Carb Steady Homemade vanilla with use by date of 1 [DATE] was observed.</p> <p>During an interview on [DATE] at 11:21AM, the Dietary Aide #1 stated they get deliveries weekly and rotate items at the end of the month when new items come in. In the dry storage new items are placed in the back and older items in the front. Dietary Aide #1 also stated they noticed some expired items two weeks ago and at the end of last month they did not have time to get rid of the items. Dietary Aide #1 further stated that they do not have a supervisor on the weekend and their new supervisor started yesterday.</p> <p>During an interview on [DATE] at 11:01AM, Certified Nursing Assistant #4 was interviewed and stated that they do not normally have anything to do with the box of supplements, and there are no residents on the unit that receive Nepro but there are residents who use Ensure supplement. Certified Nursing Assistant #4 also stated that the kitchen staff drops off the supplements and leaves them in the pantry. Certified Nursing Assistant #4 further stated that when they get supplements for residents, they look for the resident's name, residents room number and check to see if the supplement is expired.</p> <p>(continued on next page)</p> |   |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>335637   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>09/10/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brooklyn-Queens Nursing Home   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2749 Linden Blvd<br>Brooklyn, NY 11208 |  |
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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview on [DATE] at 11:07AM, Licensed Practical Nurse #4 stated they went into the cabinets in the pantry to get cups and they did not notice the expired supplements but believes no residents on the unit are using that supplement. Licensed Practical Nurse #4 also stated that the supplements expired on 1 [DATE], and should have been thrown out. Licensed Practical Nurse #4 further stated that supplements are brought up to the unit on a tray by food services and are typically not brought up in boxes.</p> <p>During an interview on [DATE] at 11:22AM, Registered Nurse Supervisor #1 stated that they do not believe the supplements were given out. Registered Nurse Supervisor #1 that the last time they did rounds on the unit they did not look at the pantry, however the nurse on the floor should be checking the pantry along with the Certified Nursing Assistants. Registered Nurse Supervisor #1 further stated that they did do not know how the supplements got in the pantry and normally the kitchen does not send up expired items.</p> <p>During an interview on [DATE] at 12:53PM, Dietary Aide #1 was interviewed, and stated they delivered today's 10AM snacks and supplements to the units. Dietary Aide #1 also stated they did not look in the pantry cabinets as they did not think dietary department had anything in the cabinet, and they bring supplements to the unit every day labeled with that day's date. Dietary Aide #1 further stated that the last time there was a resident receiving Nepro was in February 2024.</p> <p>During an interview on [DATE] at 03:25 PM, the Food Service Supervisor stated that they supervise dietary staff, and they look at the dry storage store room area three times a week, and at the emergency storage area two times a week. The Food Service Supervisor also stated that they inspected the dry storage room once a week on Mondays and did not notice the expired items on the shelf. The Food Service Supervisor further stated that the Dietary Aide is in charge of the storeroom and responsible for putting away food deliveries. The Food Service Supervisor stated that they do not give boxes of supplements to the units or look at the pantries upstairs, and they do not know who checks to see whether there are expired food items upstairs.</p> <p>During an interview on [DATE] at 12:49PM, the Director of Nursing stated when they do random unit checks they do not zero in on any particular area, and they do not look in the cabinets in the pantry. The Director of Nursing also stated that the Certified Nursing Assistants and Dietary staff have responsibility for the pantry. Supplements and enteral feeding are not kept in the pantry and are brought up to the units and labeled to be used at specific mealtimes. The Director of Nursing further stated that enteral feeding would come up per the order for administration and are not to be stored prior to use, as someone might see it there and use it which is not according to their protocol. The Director of Nursing stated the Licensed Practical Nurse or Registered Nurse supervisor should be supervising the Certified Nursing Assistants on the unit.</p> <p>10 NYCRR 415.14(h)</p> |   |  |